INSTRUCTIONS FOR COMPLETING THE OUT-OF-NETWORK CLAIM FORM

(Press Tab to go to the top of the form)

1. Sign the claim form where it asks for “patient signature.”

2. Attach an itemized copy of your bill that gives a breakdown of the cost and type of:
   - ◆ frame
   - ◆ lens
   - ◆ lens options
   - ◆ contact lenses
   - ◆ exam

3. Return the completed claim form and itemized bill to the address listed in the lower right-hand corner of the claim form.

Claims properly filled out will be processed within 1-2 weeks of receipt. Payment may be delayed on any claim missing information.

Please call 1-800-334-7591 if you have any questions.

SF 4400-VIS # (12-98)
Supersedes (1-98) issue

Sandia National Laboratories

VISION CARE

VISION CARE OUT-OF-NETWORK CLAIM FORM

PLAN #: **40367** PLAN NAME: **Sandia National Labs**

PATIENT INFO

INSURED NAME (Last Name, First Name)	PATIENT NAME (Last Name, First Name)			INSURED SOCIAL SECURITY NUMBER
ADDRESS CITY STATE ZIP			PATIENT DATE OF BIRTH	RELATIONSHIP TO MEMBER ☐Self ☐Spouse ☐ Dependent

I acknowledge receiving the services specified below. I authorize release of any information related to this claim to the Plan and/or Claims Administrator of this Vision Care Plan. Any allowable or covered benefits will be reimbursed t the insured.

PATIENT'S SIGNATURE: _____ DATE: _____

EXAM

DATE OF SERVICE	SERVICE RENDERED	EXAM FEE
_____ (Month/Day/Year)	☐Spectacle Exam ☐DW Contact Exam ☐EW Contact Exam	$
PROVIDER'S NAME ADDRESS CITY STATE ZIP		TELEPHONE NO. Area Code ( )

MATERIALS

DATE ORDERED:		Sphere	Cylinder	Axis	Prism	Add
	R					
	L					

Frame Name: _____ Retail $ _____ **DO NOT MARK IN THIS BOX**

LENS TYPE	Retail	OPTIONS	Retail		Retail	CONTACTS	Retail
☐Single Vision	$	☐Polycarbonate	$	☐Solid Tint	$	☐Hard	$
☐Bifocal	$	☐Progressive	$	☐Gradient	$	☐Soft	$
☐Trifocal	$	☐Scratch Coating	$	☐Photochromic	$	☐Daily Wear	$
☐Other	$	☐Ultra-Violet Coating	$	☐A/R Coating	$	☐Extended Wear	$
		☐Warranty	$	☐Other	$	☐Other	$

EXAM	$
FRAME	
LENSES	
OTHER	
TOTAL	
BILLED	

LOCATION WHERE SERVICE PROVIDED:

Store Name:

Address:

Phone Number: (___) _____

MAIL CLAIM TO:

COLE MANAGED VISION
A Cole National Company
1925 Enterprise Parkway
P.O. Box 8057
Twinsburg, OH 44087-8057

Cole Vision Services Federal I.D. #34-1733137

A/P USE ONLY

FORM #v1060-1297